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ABSTRACT

In this booklet, one of a series intended to apply economic principles to major social and political issues of the day, the workings of the American insurance industry, a central part of the American economy, are described. Insurance provides a means to transfer or spread risk, thus helping to assure economic survival despite chance, accident, or natural disaster. The discussion begins by considering the history of insurance from the time of Hammurabi to the present, with particular attention paid to the history of the insurance industry in the United States and the role of state regulation on the industry. Then insurance is defined and the differences between government and private insurance are discussed. Under private insurance, the difference between proprietary and cooperative insurers is explained. Also covered are the principle of risk, insurance contracts, underwriting and rating, and insurance losses. Life insurance, health insurance, automobile insurance, property insurance, and retirement and insurance are covered in separate sections. Among the areas discussed in these sections are types of coverage, rates, group and individual policies, Social Security, and Medicare. (IS)

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Insurance is Everybody's Business

Insurance is everybody's business. Insurance requires the contribution of small sums of money by many individuals to form a pool. The contributors agree to reimburse members of the pool for certain losses. When losses occur, as from fire, theft, or accident, sums are withdrawn from the pool and paid to the policyholder as stated by the agreement or policy adopted by the contributors. The pool is administered by a business firm called an insurance company.

It would be difficult to imagine our modern world without insurance, so essential a role does it play today in the conduct of government, business, and individual affairs. Insurance, along with the creation of the corporation, are among the primary causes for the growth in prosperity enjoyed by much of the world in the last two centuries. Incorporating provides limited liability and a means to raise capital. Insurance provides a means to transfer or spread risk, thus helping to assure economic survival despite chance, accident, or natural disaster.

Each person who pays an insurance premium takes a "share" in guaranteeing other members of the group against loss. Insurance seeks to remove or reduce the impact of chance and accidents on economic decisions. Insurance comes in a multitude of forms and packages. It is difficult for the average individual to know what kinds of insurance exist and what insurance is best for him or her. Some insurance is required by the federal government, such as social security, Medicare, and Medicaid. State law often requires some form of insurance, such as automobile liability insurance. Lenders generally require insurance on the life of the person borrowing money or on the loan itself. Most insurance is elective, that is, it is bought by the individual to serve a specific purpose or function. Life insurance, automobile insurance, and health or medical insurance are the most popular and common types of insurance coverage. Yet there are numerous insurance companies and kinds of policies and coverages available in each of these areas. Moreover, each state has different laws and regulations affecting insurance and insurance companies. Despite the fact that insurance is one of the most prevalent facts of everyday life, it is a subject about which most people are very ignorant.

Insurance is a very old business, dating back at least to the time of Hammurabi (2067-2025 B.C.). Until the modern era, insurance was associated almost exclusively with trade and commerce, most often with maritime cargoes. The Phoenicians, the Athenians, and Rome used forms of insurance in their sea commerce. The Dutch and British, who were the major commercial carriers of the world in the seventeenth and eighteenth centuries, became the primary insurers of the modern world.

*An edited condensation of the book *Understanding Texas Insurance* by Douglas Caddy, published by Texas A&M University Press, 1984.

Until the seventeenth century, insurance was "underwritten," that is, agreed to by individuals or associations of individuals, much as is done now by Lloyd's of London.

The great fire of London in 1666 seems to have stimulated the establishment of the first organized stock insurance company. Nicholas Barbon organized the Fire Office, which sold insurance on brick buildings at 2.5 percent of their annual rental value or 5 percent on the annual rental value of wood structures. Although the City of London organized its own insurance program, the courts soon forced its abandonment, and insurance in England remained a private business.

Many new private companies, such as the Friendly Society and, in 1696, the Hand-in-Hand, the first mutual company, were organized in England before 1700. The Hand-in-Hand, which was absorbed by the Commercial Union Assurance Company of London in 1905, became the model for America's first insurance company, the Philadelphia Contributorship for the Insurance of Houses from Loss by Fire, organized by Benjamin Franklin in 1752. In 1763 company directors specified that only the interest on deposits (premiums collected) could be used as operating money, thereby establishing the first insurance company reserve accounts.

No life insurance companies were organized in North America during the colonial or confederation periods, although two British companies organized in 1719 did business in the colonies after 1741. A Presbyterian minister's relief fund was the first prototype of a life insurance company, but the relief fund was not a true insurance company in that it depended upon "outside" or charitable contributions. Life insurance did not become popular in the United States until the mid-eighteenth century.

The tontine movement of the seventeenth and eighteenth centuries somewhat discouraged investment in life insurance because of the speculative, gambling nature of the tontine. The tontine was essentially a bet-your-life scheme, whereby survivors divided the pool among themselves after a specified number of years or when a certain number of contributors remained. Also, inadequate and inaccurate mortality tables and vital statistics made premium setting hazardous. But it was more likely changing social values, which accepted the "scientific" notion that life insurance was a form of economic immortality, that triggered its widespread acceptance following the 1850s. The American life insurance industry thereafter began to prosper.

By 1890 life insurance coverage in effect reached an astounding $5 billion. Property and casualty coverage also expanded greatly. This was a result, in part, of the widespread concern for insurance that the great Chicago fire of 1871 generated. Moreover, insurance, both life and casualty, grew apace with urban growth. Insurance was largely an urban phenomenon, and the expansion of coverage was more than proportion-

al to the increase in urban populations. According to R. Carlyle Buley in his history of the American Life Convention, "the details and scope of modern life insurance are largely of American origin,"* and, one might add, of relatively recent origin. A number of important occurrences in the late nineteenth and early twentieth centuries affected the development of both life and casualty insurance.

The Actuarial Society of America, organized in 1889, established a professional body dedicated to the preparation and maintenance of accurate data relating to mortality rates and risks. The National Association of Life Underwriters, organized in 1890, was an association of insurance agents, the agent having become the vital marketing device in the insurance industry. By 1890 there were fifty legal reserve life insurance companies organized in the United States, and in 1892 approximately one-half of the world's total life insurance force covered American policyholders. Over the next fifteen years the number of companies and premium income more than doubled.

Although the insurance industry expanded rapidly in the late nineteenth century, phenomenal changes occurred in the first decades of the twentieth century. Population growth, particularly urban growth, contributed to the change. American manufacturing and foreign trade, as well as domestic sales, expanded enormously between 1900 and 1920. U.S. population increased by 40 percent in these two decades. By 1920, for the first time in U.S. history, more Americans lived in the city than in the country. But in addition to these vital statistics, a number of unique factors contributed to the proliferation of life, property, and casualty coverage. The previously mentioned organization of the American Life Convention was a factor. The San Francisco fire and earthquake of 1906 (as had the Chicago fire of 1871 and the Boston fire of 1872) generated enthusiasm for insurance, especially when the industry generally honored the substantive losses incurred. Texans were singularly alerted to the desirability, if not the necessity, of property and casualty insurance by the natural disaster inflicted upon Galveston in the storm of 1900.

Man-made things also stimulated insurance sales. The advent of the automobile and the successful marketing of automobile insurance by such industry leaders as James S. Kemper, who founded Lumbermen's Mutual Casualty Company in 1912, and George Jacob Mecherle, who organized State Farm Mutual in 1922, invigorated the insurance industry. Automobile insurance premiums rose from none in 1900 to $1.25 billion in 1946 to $14.6 billion in 1970. Relatively few Americans are untouched by auto insurance coverage. In a very real sense, it was not just the automobile but the general expansion of commercial activity, population growth, personal wealth, and personal mobility that contrib-

*Carlyle Buley, *The American Life Convention, 1906-1952: A Study in the History of Life Insurance* (New York: Appleton-Century-Crofts, 1953), p. xii.

uted to the rapidly rising volume of property and casualty insurance. Rapid expansion contributed to problems developing within the industry and to public and private efforts to deal with those problems.

In New York a feud within the management and stockholders of Equitable Insurance Company led to public charges of improper accounting and questionable investment policies. Subsequently the New York insurance commissioner conducted an investigation and charged Equitable with irregular, if not illegal, activities. The governor next called a special session of the legislature that created an investigating committee headed by State Senator William W. Armstrong. For four months in 1905 the committee conducted widely publicized examinations of insurance and business executives. The disclosures were often embarrassing and shocking, even to the industry. The result was the adoption of a report making specific recommendations for insurance reforms, including standardized policy forms, a limit on commissions to agents, a prohibition on prizes and bonuses, legal liability for misrepresenting the terms of an insurance contract, uniform accounting procedures, and a prohibition on investments by insurance companies in common stocks. Most of the Armstrong recommendations were soon enacted into law in New York and other states.

In addition, the organization at Chicago in 1905 of the American Life Convention, comprising largely western and southern life insurance representatives, brought new pressures to bear on legislative reform. The conference favored uniform state laws for the protection of policyholders and opposed federal supervision and controls. The conference and the backwash of the Armstrong investigation influenced legislation in Texas and other states such as Wisconsin. Wisconsin adopted a package of insurance legislation in 1907, which included a requirement that companies selling insurance in the state must deposit securities with the state's secretary of state equal to the value of the policies in force in Wisconsin. Out-of-state insurance companies threatened to withdraw if Wisconsin Governor Robert M. LaFollette signed the bills. He signed, and at least fifteen insurance companies discontinued their Wisconsin operations. The state felt obliged to repeal the policy in 1915.

In Texas, under the administration of Governor Thomas M. Campbell, the legislature adopted comprehensive regulations for life, health, accident, home, and fire insurance. And somewhat like the Wisconsin act, the Texas legislature approved the Robertson Insurance Law of 1907, which required life insurance companies to invest 75 percent of life insurance reserves in Texas securities. Also in 1907, Texas separated the duties of the commissioner of insurance from agriculture and joined them with banking responsibilities to create the office of commissioner of insurance and banking (1907-13). A battle erupted in the legislature, but the bill was approved. Twenty-one insurance companies soon dis-

continued operations in Texas, arguing that the Robertson Law was unfair and unreasonable. Unlike in Wisconsin, Texans refused to repeal the law despite a concerted effort in the legislature in 1915, and the Robertson Law remained effective until 1963. That act had much to do with the growth and development of a nationally significant Texas-based insurance industry, which has been ranked by some as Texas' second biggest business, after oil.

Insurance is the only interstate industry that is regulated primarily by the states instead of the federal government. In most industries government has increasingly exercised influence or control over economic decisions through large-scale public spending, taxation, and regulatory legislation. There are presently about fifty-six major federal regulatory agencies that employ over ninety-thousand persons and operate on budgets in excess of $6 billion. Before 1900 the only two major regulatory agencies were the U.S. Patent Office and the Interstate Commerce Commission. Regulation was greatly extended during the Progressive Era under the leadership of presidents Theodore Roosevelt and Woodrow Wilson. Banking, for example, which had been under direct federal authority in the early 1800s, became essentially state controlled until 1913, when Congress enacted the Federal Reserve Act. World War I, the Great Depression and New Deal programs, and World War II brought greatly extended federal authority over most business activities—if not directly, then indirectly through federal labor, banking, interstate commerce rulings, court decisions, and tax policies.

Federal control over insurance appeared imminent when the Supreme Court, in 1944, held insurance to be a commercial enterprise within the meaning of the Commerce Clause of the Constitution and thereby subject to regulation by the federal government. After strong lobbying efforts by the insurance industry, particularly the National Association of Insurance Commissioners, however, Congress effectively blocked federal assumption of authority in this area by interposing a unique piece of legislation, the McCarran-Ferguson Act of 1945.

The legislative and regulatory history of the insurance industry can be briefly summarized by a series of Supreme Court cases that began in 1868.

In 1868 the U.S. Supreme Court in *Paul* v. *Virginia*, 8 Wall, 168, recognized the right of state governments to regulate the insurance business. This ruling prevailed until 1944, when the Supreme Court reversed itself in *United States* v. *South-Eastern Underwriters Association*, 322 U.S. 533, saying that the business of insurance was interstate commerce and, therefore, was subject to federal regulation. It declared, "No commercial enterprise of any kind which conducts its activities across state lines has been held to be wholly beyond the power of Congress under the Commerce Clause. We cannot make an exception of the business of insurance."

Congress immediately responded to the Court's decision by passing the McCarran-Ferguson Act in 1945, which served to warn the states that bad business practices by the insurance industry had better be cured through state regulation or else federal law would be imposed.

Although insurance regulation continues to be an active area for federal inquiry, it remains under the authority of the state rather than the federal government. This may change as financial intermediaries, that is, banks, insurance companies, and savings and loan institutions, join under the umbrella of corporate conglomerates or begin to duplicate financial services. Insurance companies, for example, as managers of annuity and retirement accounts are increasingly involved in banking and brokerage activities and thus are subject to federal regulation through banking and securities and exchange policies.

Nevertheless, today the sale and terms of an insurance contract are determined by state law. Thus, it is important as a consumer and a citizen of a state to be aware of the general nature of state laws affecting insurance.

Definitions

Generally, insurance can be divided into two main categories: government and private. Government insurance is either compulsory, such as social security, or voluntary, such as federal depository insurance. Government insurance plays a large role in business and individual activities. Private insurance falls within two large divisions: personal and property. Personal casualty insurance includes fire-marine and casualty-surety. There exist, of course, many subdivisions within these two general headings.

The most recent figures available, those for 1980, reveal that the private insurance industry had approximately $677 billion in assets. Premium receipts in 1980 for personal insurance were $107.7 billion; for property insurance, $95.58 billion. Nearly forty-nine hundred insurance companies operate in the United States, providing 1.9 million jobs. Private insurance companies today can be classified into two main categories: life and property. Life insurance companies generally provide life coverage and, often, medical coverage. Property companies offer protection for liability, automobiles, homes, buildings, and personal property.

Insurance companies are chartered or incorporated by state governments, and the industry is unique in that laws and regulations affecting it are almost exclusively state approved. The federal government has left the business of regulating the insurance companies to states. Insurance purchasers, therefore, should have some knowledge of the state regulations and regulating bodies affecting insurance in their home state.

Tables 1 and 2 respectively show the number of property and life insurance companies organized under the laws of various states. Il-

linois, New York, Texas, Pennsylvania, and Wisconsin appear to be most hospitable to property/casualty insurance companies. The reasons Texas has so many domestic property/casualty companies is partially explained in the comment on state regulation. Arizona, Texas, and Louisiana clearly have laws and tax structures that are friendliest to life insurance companies.

Table 1.
Property-Liability Insurance Companies by State, 1981

State	Home Offices	State	Home Offices
Alabama	21	Missouri	79
Alaska	9	Montana	4
Arizona	16	Nebraska	35
Arkansas	28	Nevada	2
California	134	New Hampshire	30
Colorado	47	New Jersey	40
Connecticut	38	New Mexico	25
Delaware	92	New York	213
District of Columbia	14	North Carolina	55
Florida	44	North Dakota	39
Georgia	31	Ohio	151
Hawaii	11	Oklahoma	56
Idaho	5	Oregon	12
Illinois	286	Pennsylvania	203
Indiana	103	Rhode Island	17
Iowa	48	South Carolina	24
Kansas	34	South Dakota	57
Kentucky	34	Tennessee	48
Louisiana	20	Texas	209
Maine	20	Utah	8
Maryland	30	Vermont	14
Massachusetts	45	Virginia	42
Michigan	49	Washington	23
Minnesota	175	West Virginia	19
Mississippi	6	Wisconsin	201
		Wyoming	3

Source: State insurance departments.

In 1982 there were 2,035 legal reserve life insurance companies in the United States. Arizona had the largest number of domiciled companies, followed by Texas. In 1981 there were 2,953 property and liability

Table 2.
Number of U.S. Life Insurance Companies by State, Mid-Year 1982

State	Number	State	Number
Alabama	33	Nebraska	30
Alaska	1	Nevada	3
Arizona	534	New Hampshire	4
Arkansas	25	New Jersey	14
California	52	New Mexico	7
Colorado	23	New York	70
Connecticut	22	North Carolina	24
Delaware	55	North Dakota	9
D.C.	10	Ohio	44
Florida	42	Oklahoma	71
Georgia	29	Oregon	7
Hawaii	8	Pennsylvania	58
Idaho	6	Rhode Island	8
Illinois	91	South Carolina	26
Indiana	57	South Dakota	9
Iowa	35	Tennessee	23
Kansas	20	Texas	226
Kentucky	15	Utah	14
Louisiana	103	Vermont	4
Maine	5	Virginia	12
Maryland	13	Washington	22
Massachusetts	17	West Virginia	2
Michigan	27	Wisconsin	30
Minnesota	21	Wyoming	2
Mississippi	26	Total U.S.	2,035
Missouri	44		
Montana	2		

Note: Data are based on reports from individual state insurance departments. These companies are considered legal reserve life insurance companies by their respective state insurance departments but may not meet the requirements for this classification as set by other states.

Source: American Council of Life Insurance.

insurance companies in the nation. Illinois had 286 such companies with their home offices located there, followed by New York with 213 and Texas with 209.

Types of Insurers

Government insurance programs, whether voluntary or compulsory, are operated as part of either the federal or state government. Insurance companies governed by the laws of Texas and most other states generally fit the following categories and descriptions.

Private insurers are either proprietary or cooperative. Proprietary insurers, meaning those owned by a private company or person, may be unincorporated or incorporated. The leading example of an unincorporated proprietary insurer is Lloyd's of London, which is actually not an insurance company but a private association of individuals who write insurance for their own accounts. They usually provide property and liability insurance. The success of Lloyd's of London has spawned Lloyd's Associations operating in the United States. These are unincorporated associations of individuals who underwrite a specific portion of liability on a policy. Thirty-one of these exist at the present time—twenty-nine of them in Texas, which does not apply rating laws to Lloyd's Associations.

An incorporated proprietary insurer is the capital-stock insurance company. It is similar in structure and operation to any for-profit business corporation. The capital and paid-in-surplus are subscribed to by stockholders. Capital-stock insurers write almost 75 percent of property insurance but only 50 percent of life insurance.

A mutual insurance company is a consumer corporation that writes insurance for its owners, the policymakers. In theory, much of the profit from the mutual's operations is distributed among the insured since no capital stock exists. Other profit goes to strengthen the organization. In actual practice, most mutual insurers, which are run by professional managers, put the profit back into their operations.

Some mutual companies encourage their policyholders to vote; others do not. One study in the *Wisconsin Law Review* found "of 18,704,879 policyholders of Prudential in 1968, only 592 voted in person, one by mail. Of 3,345,479 policyholders of Equitable Life Insurance Society, 12 showed up in person and 35 voted by mail. And of more than 22,000,000 policyholders of Metropolitan, none voted that year because the company didn't have an election."*

In 1981, mutual insurance companies provided 44 percent of the total life insurance in force in the United States, and capital-stock companies provided the remaining 56 percent.

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*Walter S. Kenton, Jr., *How Life Insurance Companies Rob You and What You Can Do About It* (New York: Random House, 1982), p. 51.

Reciprocal exchanges and mutual insurance companies are examples of consumer cooperatives. There exist, also, producer cooperatives. One example of the latter is Blue Cross and Blue Shield, in which the insurance is provided by the hospitals and doctors belonging to the system.

The Principle of Risk

Fundamental to understanding insurance is understanding the role risk plays. Insurance exists because risk exists. Without risk, there would be no need for insurance.

Insurance can be defined as a means to reduce risk or the uncertainty of loss by bringing together enough entities exposed to loss to make their individual losses collectively predictable, often referred to as the Law of Large Numbers. Once the loss is collectively predictable, it can then be shared by all the other entities exposed to the loss.

Three primary sources of risk commonly encountered are those to the person, those involving loss or damage to property, and those involving liability for injury to the person or property of others.

Since risk is at the center of the need for insurance, what are the best ways to treat risk? One way is to minimize loss. This is done by *avoiding* as many risks as possible. One example of this is to use public transportation rather than to own an automobile. A second way to treat risk is to *retain* the risk when doing so is the most economical solution. For example, an individual may not cover personal possessions when the insurance premiums are so expensive that they soon exceed the total of the belongings being insured. A specific example is declining to have collision insurance on one's personal automobile. The person who does so accepts the risk of loss. A third way to treat risk is to *transfer* it. Having automobile collision insurance is an example of how to shift risk.

In recent decades risk management has become an integral part of modern business. A risk manager is employed or consulted on the various risks facing the business and the best way to treat them.

Insurance Contracts

Generally speaking, insurance salesmen do not offer insurance for sale but instead solicit prospects to apply for insurance. The document filled out and signed by the applicant is not a contract; it is only an application for an insurance policy. The insurance policy is the contract.

The insurance company will determine, based on the information provided by the applicant in his application and on other independent information, whether to grant a policy (a contract).

The law of contracts plays a key role in insurance, which is an intangible product. The insurance salesman is not selling a concrete and tangible product, such as a television set. Instead, he is selling a concept

or idea, which becomes embodied in the insurance policy once it is issued.

The law governing contracts requires that four essential requirements must be met before a contract exists: (1) offer and acceptance, (2) a legal object for the agreement, (3) competent parties, and (4) consideration.

Offer and acceptance: In life insurance, the act of the applicant completing his written application and tendering his first premium is the offer. A salesman may issue a "conditional receipt." Acceptance does not take place until the insurer determines that the applicant meets the underwriting standards and issues the policy. The policy represents a promise to perform, and its issuance is an acceptance of the offer tendered by the applicant.

In property insurance, an applicant may make an oral offer to take out an insurance policy and the insurance agent can "bind" the contract by an oral acceptance. The agent can then issue a binder, which is a temporary policy, until the written contract is issued shortly thereafter.

Legal object: The agreement must have a legal object. For example, an applicant attempting to insure property he has stolen will fail since the object of the contract is not legal.

Competent parties: The law will not recognize an agreement when one or more of the parties are not competent. A legally insane person or a very young minor would not be considered competent parties.

Consideration: This means something is given up or an obligation is assumed. An applicant's insurance premium and the insurer's promise to honor certain losses constitute consideration.

In 1982 there were 389,560,000 life insurance policies or contracts in force in the United States that had met these four requirements for a total amount of $4,476,659,000,000 ($4.5 trillion). Two-thirds of all Americans own some form of life insurance.

In addition to the four general requirements that must be met in a valid insurance contract, there are also some special characteristics that may be applicable. For example, property and liability contracts generally are contracts of *indemnity* because they compensate the insured for loss or damage actually sustained. This is not true of life insurance policies, which pay the face amount upon the insured's death. Another characteristic of property and liability insurance is *subrogation*. This allows the insurer to get from the insured an assignment of all rights of recovery against the party that caused the loss. Another is that insurance contracts are *personal*, that is, they go with the person rather than the property. Thus, should a person sell his property to another without transferring his policy, the insurer will not pay the original owner if the property undergoes a loss, because the original owner has suffered no loss.

A key characteristic of insurance contracts is that an *insurable interest* must exist. In life insurance the insurable interes. is any reasonable expectation of financial loss if the person whose life is insured dies. In property insurance the insurable interest is some legal right in maintaining the property.

In broad terms, life insurance requires an insurable interest at the same time the contract is purchased. Property insurance requires that an insurable interest exist at the time of loss. The requirement of an insurable interest assumes that the policyholder has an interest in the preservation, not the destruction, of the subject of the insurance, whether it be a life or property. Insurable interest is an expression of public policy that a person should not profit through an insurance policy by destroying the subject covered by the insurance.

There are certain circumstances that allow an insurer to void an insurance contract. These are concealment, misrepresentation, warranty, and fraud. In order to void a contract, the concealment must be important, the representation must be false and material, the warranty must be false and be designated a warranty in the contract or application, and the fraud must be false for the purpose of deceiving and must be relied upon by the insurer.

Underwriting and Rating

Frequently an applicant for insurance will be told by the insurer that his application must "go through underwriting." Underwriting is the company function of accepting or rejecting risks. The word "underwriter" grew out of the custom of individual insurers at Lloyd's of London writing their names under a marine insurance proposal, thus indicating that for a share of the premium they would share the risk.

Insurance agents are underwriters in the limited sense that they screen out potential applicants who are bad insurance risks. In actual practice the bulk of the responsibility for accepting or rejecting risks lies with the insurer's underwriting department. Underwriters will use a variety of sources of information in making this decision: the application, reports by the insurance agent, and inspection reports.

Once the underwriter has reached the decision to accept the application, the next question is whether the dollar amount of the risk is so large that the insurer must share it with other insurers. If the insurer does wish to share the risk, he does it through *reinsurance*. Reinsurance is the insurance of insurance. The insurer frequently works out an agreement with a reinsurer whereby a designated amount or class of insurance will automatically be referred over for reinsurance. Thus, insurance companies, through reinsurance, share the risks.

Ratemaking is the pricing of insurance. The premium is the amount the insured pays for his insurance requested. Ratemaking uses the *actuary* to determine what the rates should be. An actuary is the

statistician who evaluates the historical experience of an insurance contract or risk to determine the probabilities of loss and who sets the rates.

Insurance Losses

A policyholder owns an insurance policy for the purpose of covering a specific loss if that loss should occur. The insurance company exists to cover losses covered by an insurance policy. The underwriting loss for property and casualty insurance business in 1980 represented 3.55 percent of earned premiums of $93.85 billion. This means that for every $100 the industry earned in premiums that year, it incurred $103.55 in losses and expenses. Property/casualty losses have risen because of increased costs fueled by inflation and because rates tend to lag behind real cost increases.

Great disasters such as fires and floods have created unusual losses in the past. Table 3 lists the fires that have caused the greatest property damage and loss in the history of the United States.

When a loss occurs, an insurance *adjuster* is called into action. The adjuster evaluates the extent of damage or loss and recommends an amount to be paid the insured for the losses incurred. In life and property insurance claims, the insurance agent usually acts as the adjuster. Sometimes other representatives of the insurer may participate; they are called staff adjusters. Independent adjusters may be used by insurance companies because of their specialized experience. Adjustment bureaus play a similar role. Public adjusters are retained by the insured, not the insurer, to negotiate an adjustment.

Each insurer has certain procedures that must be followed for the claim to be honored. In most contracts relating to property/casualty insurance, loss requirements for both parties are embodied within the policy.

Most people use four basic types of insurance: Life Insurance, Health Insurance, Automobile Insurance, and Property and Casualty Insurance. A brief overview of these insurance programs follows.

Table 3.
The Eleven Most Costly Fires in the United States

Date	Place	Property Destroyed	Estimated Loss
April 18, 1906	San Francisco, Calif.	28,000 buildings	$350,000,000
Oct. 8-10, 1871	Chicago, Ill.	17,340 buildings	175,000,000
Nov. 9, 1872	Boston, Mass.	776 buildings	75,000,000
Sept. 1, 1979	Deer Park, Texas	Tank ship	70,000,000
Apr. 16, 1947	Texas City, Texas	Waterfront industrial area	67,000,000
Feb. 27, 1975	New York, N.Y.	Telephone central office	56,500,000
Feb. 7, 1904	Baltimore, Md.	80 city blocks in business section	50,000,000
Aug. 12, 1953	Livonia, Mich.	Auto transmission plant	50,000,000
Dec. 5, 1970	Linden, N.J.	Oil refinery, nearby buildings	50,000,000
Jan. 20, 1980	Borger, Texas	Refinery	50,000,000
Nov. 21, 1980	Las Vegas, Nev.	Hotel	50,000,000

Source: Compiled by the Insurance Information Institute.

Life Insurance

Term Insurance

A term life insurance policy may be defined as a contract that provides life insurance protection for a limited period of time. The death benefit is usually sold in one-thousand-dollar units and is payable only if death occurs during that term presented by the insurance contract. The term periods are typically in years (for example, one year, five years, ten years, or to age sixty-five). The most common term life insurance policy is yearly renewable and convertible term insurance.

Yearly renewable and convertible term insurance provides insurance protection for a period of one year. At the end of that year the renewable feature allows the owner of that contract to renew for an additional year by paying only the renewable premium. (Premiums will be discussed later.) Renewability may occur for successive one-year periods without providing evidence of insurability. In other words, no medical examination, no medical questions, and no other evidence of good health is required to renew the policy.

The convertible feature of this type of policy grants the owner the privilege to change policies within the same insurance company to a level premium type of life insurance policy. (The level premium policy will be the next type discussed.) The key to this convertibility feature is that this exchange may also be executed without providing any evidence of insurability. One of the motivations to exercise this privilege is that

yearly renewable and convertible term insurance is usually renewable only until some predetermined age is reached, such as age sixty-five or seventy. Since the average life expectancy is usually beyond that predetermined age, it is necessary to convert to a level premium policy in order to provide life insurance protection for the lifetime of the person insured.

One very popular term policy that has been developed for a specific commercial function is decreasing term insurance. This is the kind of insurance that is most commonly used to guarantee repayment for different kinds of loans. If a home is purchased, then mortgage insurance, which is decreasing term insurance, is usually offered and often required by the lender to guarantee payment of the mortgage against the home. The major difference between this type of term insurance and the yearly renewable and convertible term is that the death benefit, or policy proceeds that will be payable because of death, are declining in value either monthly or annually. For example, a $1,000 decreasing term policy that has a term period of twenty years will pay as a death benefit in the nineteenth year as little as 10 percent of the original amount, or $100. Another distinction of this kind of policy is that the premium payable will not be increasing each year to the buyer. The real rate per $1,000, however, does increase because the insurance coverage is declining in value either monthly or annually until expiration of the term period.

Level Premium Insurance

Level premium insurance is synonymous with other descriptive names such as "whole life insurance," "ordinary life insurance," "life paid up at sixty-five," and other less common names. These types of policies have two primary characteristics in common. One is that premiums are level and do not increase with age. The second is that the policy provides lifetime protection.

Universal Life Insurance

Universal life was first introduced by E. F. Hutton Life Insurance Company in 1978. Hutton waited until 1979 to market universal life in order to obtain a private letter ruling from the Internal Revenue Service stating that the interest in the account could be tax deferred. This was the beginning of a completely new product of life insurance.

As explained in the discussion of the level premium life policy, the protection element and the savings element are considered indivisible. That is, within each policy these elements are bundled together in such a way that is impossible for anyone except an actuary to separate the internal charges for protection and savings (cash value). Universal life has changed all of this.

Universal life has unbundled the level premium life insurance contract. The *protection* element, or the charge for mortality expenses,

and the *savings* element, which is the cash value fund, are no longer combined. Each of these elements is clearly identified and separated. The premium that a person is charged for universal life is broken down into its respective elements.

The money you pay into universal life may be called a premium, although many insurance companies refer to it as a contribution. Their reasoning is that this is a contribution because there is no fixed amount that must be paid each month or year. Obviously there is a minimum contribution level, below which the product could offer nothing in the way of protection or savings. Above this minimum contribution level, however, there is complete flexibility with respect to how much is deposited with the insurance company.

Once an individual establishes how much life insurance he wants, he decides what size a contribution he is comfortable with. He may decide to deposit a large lump sum of money and not be bothered with periodic contributions, or he may decide to pay the very minimum and treat his universal life policy as a term life policy. This flexibility is achieved by the way in which each contribution is handled by the insurance company.

A major difference between universal life and the other more traditional types of insurance (term and level premium) is that the face amount of the policy may be changed. The face amount is the amount of life insurance that is initially purchased. Traditionally, this amount could not be altered; therefore, if more insurance was needed at a later date, a new policy had to be purchased. Universal life has changed this. The amount of life insurance may be increased with proper evidence of insurability (good health). This feature is cost reductive since each new policy an insurance company issues requires some repetitive administrative and sales fees. In fact, some companies offer cost-of-living increase options that provide for automatic increases as inflation increases the cost of living.

Universal life is truly a new product to the life insurance industry. It provides flexibility with respect to the premium payment required, it responds to the demand for increased protection without purchasing a new policy each time, and it offers an interest rate payable on the reserve fund that is more indicative of the present economic conditions. For these reasons, universal life differs substantially from the more traditional forms of life insurance.

Group Life Insurance

Group life insurance provides benefits to a number of persons utilizing only one contract. An insurance company will issue a master policy to the group policyholder. This one policy will provide benefits to the individual members of the group. Each member receives a certificate describing the benefit of life insurance as well as the member's relation-

ship to the policyholder. Typically, the relationship between the policyholder and each member is that of employer and employee. Employee groups are not the only eligible groups, however. Creditor-debtor groups, fraternities, sororities, professional associations, and many other associations qualify for group life insurance.

Group life insurance can provide premiums that are lower than those for other individually owned life insurance. This cost reduction is achieved by lower administrative expenses resulting from mass distribution methods. The group policy is one contract. It may cover as few as ten or as many as the thousands of individuals in one labor union or employed by a large corporation. Additionally, many group policyholders are employers, and employers usually pay part or all of the cost of the group insurance for their employees. This also helps to reduce life insurance costs under a group policy.

Evidence of insurability for an individual usually is not required under a group policy. It may be required, however, if a particular member of the group has the option of purchasing additional amounts of group insurance and not simply taking what is offered. Generally, the insurance company is concerned with the insurability of the group, not with any individual member of the group.

Among the types of life insurance previously mentioned—term, level premium, or universal life—only term and level premium can be purchased as group life insurance. Ninety percent of group life insurance in force today, however, is group term life insurance. Universal life may become available as a group product, but whether it does or not, group term life insurance will remain the primary type of group insurance purchased. This is because the end user is typically an employee or member of some other large group. These members tend to be interested in the most insurance for the least amount of contribution. Term life insurance can provide that requirement temporarily. The American Council of Life Insurance calculates that of the $1,888.6 billion of group life insurance in force in 1981, $1,879.4 billion was group term life insurance.

Health Insurance

Although the growth of life insurance in recent decades has been phenomenal, the expansion of health insurance programs has been even more spectacular. Health insurance exceeds life insurance in the number of persons covered. More than eight out of ten persons are covered by health insurance today. In 1981, 188 million Americans, or 84 percent of the civilian population, had health insurance. These included 173 million persons under the age of sixty-five. Nearly 16 million persons covered by health care programs are sixty-five or older, and of these about five out of every six hold private insurance policies supplementing Medicare.

Health maintenance organizations (HMOs) offer a competitive health care program based on a fixed periodic payment by their members. Doctors and other medical personnel contract directly with the HMO to perform their services for HMO members.

Each individual should examine his own health care needs in deciding what levels of protection are required. The three levels are *basic, major medical,* and *disability.*

Basic protection provides hospitalization benefits, including payments for daily room and board and nursing services while hospitalized and payments for certain hospital services and supplies, such as X-rays, lab tests, drugs, and medication. Payments may go toward the costs of surgical procedures in and out of the hospital, doctor visits, and diagnostic and laboratory tests. Basic coverage programs usually have limitations on the amount covered for surgery and hospital rooms and on the length of the hospital stay.

Major medical, the next level, is designed to provide insurance for a long-term injury or illness and the surgery and doctor's care associated with that illness. Many persons buy a major medical policy because it covers most of their medical expenses.

A major medical policy usually requires a deductible—ordinarily from $500 to $2000. As with automobile insurance, the higher the deductible the lower the cost of the policy. Thus, most major medical policies pay 75 to 85 percent of all eligible medical costs above the deductible.

One may supplement major medical with hospital indemnity coverage. This supplementary policy pays cost benefits to the policyholder only when that person is hospitalized. The income may be used to pay medical, nonmedical, or other expenses.

The third level of protection is disability income. Under this policy an ill person can continue collecting a percentage of former earnings until he or she can return to work. The disability income policy usually has several distinct features: (1) it normally requires the beneficiary to be totally disabled before benefits begin; (2) benefits may not begin until a given period of time has elapsed, usually from one week to six months after the onset of the disability; (3) payment periods may range from thirteen weeks to a lifetime; (4) monthly payments are approximately 50 percent of normal earnings; and (5) the policy should cover disability arising from either an accident or an illness.

Group Insurance

Group insurance programs, written by private insurance companies, often offer excellent health care programs at lower costs. Employers may contribute to the premium as an employee benefit, and often the "group" may have a lower risk of illness or injury because of the nature of the employment. Another advantage of the group program

is that processing claims and payments to the insured or to medical doctors or facilities is usually handled expeditiously by a resident staff.

Typical group insurance programs include a term life insurance and an accidental death and dismemberment clause, either on an optional or a mandatory basis. Most programs cover the spouse and all family members, often without a medical examination required for enrollment. Such plans may provide hospitalization coverage for a specified number of days either on a 100-percent or lesser basis. A major medical expense schedule will pay 80 to 100 percent of the charges for surgery and medical treatment or will sometimes specify an amount payable for specific treatment.

Most programs include some deductible such that the insurance policy begins payment for expenses over and above a specified amount, a situation similar to the deductible in an automobile collision policy.

Medicare

Medicare is a government program that pays part (an estimated 41 percent) of the total cost of health care for the elderly. Some other government programs, primarily for veterans and the very poor, pay another 23 percent. The remaining costs must be picked up by a private insurance policy or by direct payment.

Medicare covers all people sixty-five or older and certain individuals under sixty-five who are disabled or who have terminal diseases.

There are two parts to Medicare—part A and part B.

Part A is hospital insurance automatically available without charge to those eligible. Persons who for some reason are not automatically eligible must pay a monthly premium, currently around $113, if they want coverage.

After the insured pays a deductible of $304, Medicare pays for sixty days of hospital care for each occurrence of illness, including all the charges customarily associated with a hospital bill, such as the semiprivate room rate, meals, regular nursing services, laboratory and X-ray fees, intensive care costs, operating and recovery room, drugs, casts, dressings, splints, and in-hospital therapy services.

If an illness goes beyond sixty hospital days, the patient is responsible for a $76 daily copayment through the ninetieth day. The program provides a sixty-day "lifetime reserve" of hospital days against which you can draw, should any illness extend beyond ninety days. For each reserve day used, the cost is $152.

After a hospital stay of at least three consecutive days, Medicare helps pay for up to 100 days of care in a skilled nursing facility, provided the nursing is certified as being connected with the illness that put the patient in the hospital. The first 20 days of nursing home care are paid in full; the next 80 days of care require a $38 daily copayment. Eligibility depends upon the insured's need for skilled medical services. The

program does not cover custodial care in a nursing home.

Medicare Part B helps pay for a number of other benefits: diagnostic tests, prosthetic devices, medical supplies, independent laboratory tests, certain ambulance services, radiology and pathology services, administration of drugs that cannot be self-administered, physical and speech therapy services, and limited outpatient psychiatric, chiropractic, and dental surgical care.

Insurance is an important vehicle in providing medical care for the individual and family members. Indeed, the high costs of medical care have made the costs, particularly when that care involves hospitalization or surgery, beyond the means of the average family. Medical care insurance, then, has become almost imperative. Insurance is available from private, independent policies; through group coverage; and, for older Americans, through Medicare. Health maintenance organizations are a relatively new form of mutual medical insurance association. Generally, Americans are spending more per capita on health care every year. The result has been a nation of healthier, longer-lived people than at any other time in human history.

Automobile Insurance

One of the largest sections of the insurance business in the United States is automobile insurance. With over 25 million accidents a year causing a total of about fifty thousand deaths and more than 5.5 million disabling injuries, automobile insurance is the largest form of property and casualty insurance today. Losses from highway accidents have reached a record $56 billion, and many experts see losses reaching $100 billion sometime during the late 1980s. Behind the large increases are the extraordinary inflationary pressures that affect the costs of automobiles and their repairs and the skyrocketing cost of medical care.

Of all the money spent on property and casualty coverage in the United States, 40 percent is spent on automobile insurance premiums. Eighty percent of premiums paid for automobile insurance are for privately owned vehicles.

Automobile insurance underwriters base premiums on the following factors:

Classifications: There are five major automobile classifications: (1) private, (2) commercial, (3) public, (4) dealers, and (5) miscellaneous. The purpose of classifying automobiles is to relate the amount of risk that each group has to the appropriate premium rate. As was previously stated, private classification is the largest.

Territory: An insured's address is extremely important when figuring premium rates. Various information such as the number of accidents within the area, average cost of repairs, and amount of thefts and vandalism all affect rates for a particular territory. Densely populated

areas allow for considerably greater exposure to risks than rural areas with lower populations.

Liability: The higher the liability coverage, the higher the premium rates.

Age and sex: Some statistics point to the fact that younger drivers are involved in more accidents than older drivers and males more than females. Interpretations of these statistics and their validity have been questioned, and some states have prohibited their use for auto insurance rating.

Usage: How often the car is driven, how many drivers are involved, and where it is driven can all affect premium rates. Drivers may be listed as primary or secondary drivers, which can be a major factor in determining premium rates.

Car's condition: The age, make, and model all are factors in determining the value of a car. Collision coverage rates are based on the value of the car being insured and the cost of the repairs.

Driving record: Number of traffic violations, number of accidents, a drunk-driving record, and previous license suspension are all negative factors that can cause premium rates to skyrocket. Applicants with poor driving records should expect to pay some of the highest premiums for auto insurance.

Miscellaneous: Marital status, completion of a driver's education program, honor student discounts, and number of auto policies owned all affect premium rates.

Many complaints about insurance stem from the extensive use of legal terminology for policy contracts. Many insurance policies written by insurance company legal departments leave policyholders confused about coverage and benefits. One of the first policy formats to use a simplified, down-to-earth insurance contract was the personal auto policy, or PAP. The PAP format modernized old auto insurance contracts by combining two contracts, the family automobile policy and the special package policy, into a single agreement, thus effectively eliminating half the wordage. Language in the contracts became more intelligible to the average consumer as a result of the use of simple terms such as "you" for the policyholder and "we" for the insurance company. Most of the coverage from the old, two-contract format was included in the new PAP contract. The policy allows the consumer to select from a range of benefits.

Property Insurance

By definition, property insurance can be classified as a "first party coverage, i.e., it covers losses to the insured's property." Property can be separated into two distinct types: real and personal. Real property is simply "the rights of ownership of land and its improvements." Person-

al property is defined as "the rights of ownership of movable or temporary objects, and includes anything not classified as real." Thus real and personal property cover a wide range, and the types of insurances that cover property losses are many.

Today the most common form of residential property insurance is the homeowner's policy. There are seven different types. HO-6 is a new policy that is especially formed to cover the needs of the condominium owner. This policy allows an individual to choose between his own policy (HO-6) or the policy that has been arranged by the condominium association. Another policy (HO-8) was written to help homeowners who have a problem maintaining insurance levels at 80 percent of replacement costs of their older home. These older homes have extremely high replacement costs because of the cost of materials. The HO-8 policy allows the policyholder to insure the residential property at the market value, thus making premium payments more reasonable.

Title insurance is another form of residential property insurance. This insurance protects against losses occurring from the purchase of property that has an encumbered title. Realizing that records can be lost and that there is always a chance that some lien exists on the property, it is normally advisable for the individual interested in purchasing property to obtain title insurance.

The insurance needs of the individual farm owner require policies that are tailored to meet those needs. Large, corporate farms can choose insurance that is available for large agribusinesses. Because the difference between home property and farm property is often difficult to determine, insurance companies have devised a multipurpose insurance called a farm/ranch policy. All farm/ranch policies require insurance coverage of 80 percent of the replacement value of property.

Boiler and machinery insurance is one of the most specialized in the insurance business, with several companies controlling over 50 percent of the market. Although premiums for the most part remain very low, boiler and machinery insurance can effectively control a potentially high exposure to financial losses resulting from an accident. Since 1978 premiums for boiler and machinery policies have averaged almost $300 million annually.

Property and casualty insurance offer a wide selection of options that seek to protect the individual from losses resulting from injury or damage to others, to their property and to one's own property or person. The most common policies providing such coverage are the homeowner's policy and the dwelling policy program. Farm insurance offers seven basic programs that are tailored to meet the ordinary liabilities and losses associated with different aspects of the industry. Boiler and machinery policies, glass coverage, comprehensive personal liability insurance designed to protect the individual from losses resulting from third-party lawsuits, crime insurance, burglary, and aviation

family bearing the responsibility for the care of the aged. As the family structure began to weaken or change under the influence of the industrial revolution, governments and other organizations began to administer this function. Charitable institutions, poor-houses, soup kitchens, the Salvation Army, churches, and philanthropists inadequately filled the rising social need for better care of the aged. Governmental assistance programs for the aged began in Europe in the early nineteenth century. Only well into the twentieth century did the United States adopt a social insurance program.

The U.S. Social Security Program, enacted in 1935, is financed through taxes on wages and self-employment income. It provides benefit payments to retired and disabled persons and their dependents and survivors and covers major medical expenses for the aged and long-term disabled.

The Social Security Act of August, 1935, passed during Franklin D. Roosevelt's second New Deal, created the Social Security Board to administer old-age benefits based upon earnings accumulated by the individual before the age of sixty-five. The original act did not include coverage for agricultural workers, domestic servants, doctors, the clergy, and the self-employed. The many amendments to the original act have broadened the coverage to include most Americans, raised benefits, and greatly increased the costs to the individual and the employer.

In 1950 contributions to social security by the employee and the employer were raised sharply, and benefits were included for the permanently disabled, although they might never contribute. In 1954, during the administration of President Dwight D. Eisenhower, eligibility was expanded to include self-employed persons. In 1956 the age of benefit eligibility for women was lowered from sixty-five to sixty-two, and compensation was scheduled for disabled workers over the age of fifty. One of the most dramatic supplements to the social security system came with the approval of Medicare in 1965, which provided medical insurance for the aged. More recent amendments have tied benefits to the consumer price index, allowing the recipient some relief from the damaging effects of inflation but also seriously eroding the fiscal soundness of the OASI fund. This situation contributed to recent efforts to maintain the fiscal solvency of the social security system.

In 1983 Congress enacted the Social Security Reform Law. It boosted payroll tax rates and removed some employers exempt until then. It forbade a cost-of-living increase in 1983 for those receiving benefits and required younger workers to work for a longer period before being eligible for benefits. It broke new ground by requiring benefits to be taxed under certain circumstances.

The spiraling costs of social security have encouraged the government to urge the individual to acquire alternative or supplemental retirement programs. The U.S. population will reach about 300 million

by the year 2000, about three times the number of citizens as a century earlier. Moreover, a greater proportion of the population will be older citizens. During the past several decades most of the population has been under the age of twenty-five. Today and most likely in the next few decades given present demographic characteristics, the average age will rise rapidly. The younger generation will give way to the mature generation. Planning for retirement will necessarily become increasingly vital to the government and to the individual. Social security will presumably continue to exist, and it is equally likely that benefits will be increasingly inadequate to provide a life with dignity after retirement.

Selected Center Publications

In an effort to reach as broad a spectrum of readers as possible, the Center for Free Enterprise publishes numerous research monographs, other papers and occasionally a full-length book. The following is a partial listing.

Research Monograph Series

The research monograph series is designed to provide interpretations of technical articles appearing in scholarly journals. The monographs often are useful for teachers who are addressing current economic issues in the classroom.

1. *The Economics of Industrial Democracy: An Analysis of Labor Participation in the Management of Business Firms,* by Eirik G. Furubotn.
2. *International Price Stabilization and the Less Developed Countries: Lessons from History,* by John R. Hanson II.
3. *Distortions in Official Unemployment Statistics: Implications for Public Policy Making,* by Kenneth W. Clarkson and Roger E. Meiners.
4. *Profitability of Major Oil Companies: Normal Returns or Windfall Profits?* by Gerald D. Keim, Barry D. Baysinger, Roger E. Meiners and Gary D. Libecap.
5. *The Inflationary Impact of Labor Unions,* by Dwight R. Lee.
6. *The Foundations of Free Enterprise,* by John W. Allen, David G. Armstrong and Lawrence C. Wolken.
7. *The Exploration and Colonization of Space,* by Lawrence C. Wolken.

Series on Public Issues

The series on public issues has been designed for use by high school teachers and the general public. The authors in the series use commonly accepted economic principles to help readers increase their understanding of complex economic, political and social issues.

1. *Are We Running Out of Everything?* by S. Charles Maurice and Charles W. Smithson.
2. *The Minimum Wage Laws: Who Benefits, Who Loses?* by Margaret Jane

Hobson and S. Charles Maurice.

3. *Japan: The Modernization of an Ancient Culture*, by Lawrence C. Wolken.
4. *The Overpopulation Myth*, by Thomas R. Saving.
5. *Entrepreneurship: A U.S. Perspective*, by Henry C. Dethloff and Keith L. Bryant, Jr.
6. *Karl Marx in One Lesson (1818-1883)*, by Steve Pejovich.
7. *Pollution in America: The Trouble with Trash*, by S. Charles Maurice and Charles W. Smithson.
8. *Is the Market Fair?* by Gerald Keim.
9. *Inflation: Causes and Cures*, by Thomas R. Saving.
10. *Value & Opportunity: Comparable Pay for Comparable Worth*, by Deborah Walker.
11. *The Revolution in Banking and the Financial Services Industry*, by Donald R. Fraser.
12. *Industrial Democracy: Conflit or Cooperation?* by Steve Pejovich.
13. *The Budget Deficit—The "Crisis" of the 80's*, by Melvin L. Greenhut and Charles W. Smithson

Other Publications

The Economic Responsibility of Government, by Milton Friedman and Paul A. Samuelson. ($1.00)

The Political Economy of Federal Government Growth: 1959-1978, by James T. Bennett and Manual H. Johnson. (Paper-$4.95, Cloth-$12.95)

Los Fundamentos de la Libre Empresa, by John W. Allen, David G. Armstrong and Lawrence C. Wolken. ($1.00) [Spanish version of *The Foundations of Free Enterprise*]

The American free enterprise system traditionally rests on three premises: the right of ownership, contractual freedom and limited government. These premises generate predictable human behavior, consistent with liberty and efficiency. Indeed, the American free enterprise system produces a standard of living and a degree of personal freedom that no other system (or country) has been able to duplicate.

The purpose of the Center for Education and Research in Free Enterprise is to enhance public understanding of individual liberty and the American Free Enterprise System through education, community involvement and research.

Admission to Texas A&M University and any of its sponsored programs is open to qualified individuals regardless of race, color, religion, sex, age, national origin or educationally-unrelated handicaps.

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$2.00

coverage are also available. Individuals needing even more unusual coverage may often obtain negotiated policies tailored to meet the specific need.

Retirement and Insurance

Insurance is an important element in planning for retirement. Retirement insurance assumes many different forms. Although the traditional whole life policy is still significant, it has become increasingly less so as new investment packages handled by insurance companies produce better results. Whatever kind of investment vehicle is used, retirement insurance means saving a part of present earnings for future use. Insurance is protection against the "economic death" implied by retirement.

One of the best-known retirement programs is social security. Social security is an old age or retirement pension program created by Congress in August, 1935. A Social Security Board administers the program and bases benefits upon earnings prior to age sixty-five. Involuntary "savings" in the form of old age survivors' and disability insurance (OASI) contributions are paid on income according to formulas established by Congress, and benefits are returned to the contributor when eligibility is established. Although most Americans are covered by social security, its benefits have often proven inadequate to sustain retirement with dignity.

Half of all full-time workers in commerce and industry in the United States and three-fourths of all government civilian personnel are now enrolled in retirement plans other than social security. Private pension plans may be self-administered or administered by boards or trust companies or by insurance companies. In 1981, insurance-company-administered plans covered 27.9 million persons and provided retirement income to 2.8 million individuals. Government-administered plans, including those for federal civilian, state, and local employees and railroad employees, covered 19.9 million persons in 1981. The keystone of the government-administered plans is the Federal Old-Age and Survivors Insurance System, which is part of the Social Security Act of 1935. Over 157 million Americans are covered by social security. It is almost imperative, however, that individuals supplement social security benefits with private retirement programs.

Social Insurance

Social old-age insurance, or, as we style it, "social security," derives from the idea that old age or the time of "economic death" is a social phenomenon over which the individual has no real control. It is the responsibility of society to protect the individual against the economic adversity of old age. In an earlier day, this was accomplished by the